Supplemental Information to the PLHCP

Before a recommendation can by made by the professionally licensed health care provider (PLHCP), OSHA requires the following information be included so it, too, can be taken under consideration:

1. *The type and weight of the respirator*
2. *The duration and frequency of respirator use*
3. *The expected physical work effort*
4. *Any additional PPE or clothing to be worn*
5. *Temperature and humidity extremes that may be encountered*
6. *A copy of [company name's] written program and a copy of OSHA's standard, 29 CFR 1910.134*

Employee Name: _____

Job Title: _____

Type of respirator:

Half mask _____
Full-face piece _____
Dust mas _____
Powered air-purifying respirator _____

Duration/Frequency of use:
Duration _____*HR*
Frequency _____*Daily*
Number of times per week _____
Number of times per month _____
Expected workload:
Light _____
Medium _____
Heavy _____

Indicate any other PPE required at same time of respirator use:

_____
_____
_____

Temperature and humidity extremes:
High Temperature _____
Low Temperature _____
High Humidity _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances you will be exposed to while using your respirator: _____

_____

_____

_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security): _____

_____

_____

_____

_____

Employee Name: _____

Signature: _____

Date: _____

b. Moderate (200 to 350 kcal per hour): *Yes* *No*

If "yes," how long does this period last during the average shift? _____ hours _____ minutes.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 pounds) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; and pushing a wheelbarrow with a heavy load (about 100 pounds) on a level surface.

c. Heavy (above 350 kcal per hour): *Yes* *No*

If "yes," how long does this period last during the average shift? _____ hours _____ minutes.

Examples of heavy work are lifting a heavy load (about 50 pounds) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; and climbing stairs with a heavy load (about 50 pounds).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes No

If "yes," describe this protective clothing and/or equipment: _____

_____

_____

14. Will you be working under hot conditions (temperature exceeding 77 F)? *Yes* *No*

15. Will you be working under humid conditions? *Yes* *No*

16. Describe the work you'll be doing while you're using your respirator(s): _____

_____

_____

_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases): _____

_____

_____

_____

18. Provide the following information, if you know it, for each toxic substance you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

4. List any second jobs or side businesses you have: _____

_____

5. List your previous occupations: _____

_____

6. List your current and previous hobbies: _____

_____

7. Have you been in the military services?	*Yes*	*No*
If "yes," were you exposed to biological or chemical agents (either in training or combat)?	*Yes*	*No*
8. Have you ever worked on a hazardous material team?	*Yes*	*No*

9. Other than medications for breathing and lung problems, heart trouble, blood pressure and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?
Yes No

If "yes," name the medications if you know them: _____

_____

_____

10. Will you be using any of the following items with your respirator(s)?

a. High-efficiency purifying air filters	*Yes*	*No*
b. Canisters (e.g., gas masks)	*Yes*	*No*
c. Cartridges	*Yes*	*No*

11. How often are you expected to use the respirator(s)? Circle "yes" or "no" for all answers that apply to you.

a. Escape only (no rescue)	*Yes*	*No*
b. Emergency rescue only	*Yes*	*No*
c. Less than five hours per week	*Yes*	*No*
d. Less than two hours per day	*Yes*	*No*
e. Two to four hours per day	*Yes*	*No*
f. More than four hours per day	*Yes*	*No*

12. -During the period you are using the respirator(s), is your work effort:

a. Light (less than 200 kcal per hour)?	*Yes*	*No*

If "yes," how long does this period last during the average shift? _____ hours _____ minutes.

Examples of a light work effort are sitting while writing, typing, drafting or performing light assembly work and standing while operating a drill press (1to 3 pounds) or controlling machines.

b.	*Back pain*		
c.	*Difficulty fully moving your arms and legs*	*Yes*	*No*
d.	*Pain or stiffness when you lean forward or backward at the waist*	*Yes*	*No*
e.	*Difficulty fully moving your head up or down*	*Yes*	*No*
f.	*Difficulty fully moving your head side to side*	*Yes*	*No*
g.	*Difficulty bending at your knees*	*Yes*	*No*
h.	*Difficulty squatting to the ground*	*Yes*	*No*
i.	*Difficulty climbing stairs or a ladder carrying more than 25 pounds*	*Yes*	*No*
j.	*Any other muscle or skeletal problem that interferes with using a respirator*	*Yes*	*No*

Employee Name: _____

Signature: _____

Date: _____

Part B. Any of the following questions and other questions may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower-than-normal amounts of oxygen? Yes No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions? Yes No

2. At work or home, have you ever been exposed to hazardous solvents or hazardous airborne chemicals (e.g., gases, fumes or dust) or come into skin contact with hazardous chemicals? Yes No

If "yes," name the chemicals if you know them: _____

_____

_____

_____

3. Have you ever worked with any of the materials or under any of the conditions listed below?

a.	*Asbestos*	*Yes*	*No*
b.	*Silica (e.g., in sandblasting)*	*Yes*	*No*
c.	*Tungsten/cobalt (e.g., grinding or welding this material):*	*Yes*	*No*
d.	*Beryllium*	*Yes*	*No*
e.	*Aluminum*	*Yes*	*No*
f.	*Coal (e.g., mining)*	*Yes*	*No*
g.	*Iron*	*Yes*	*No*
h.	*Tin*	*Yes*	*No*
i.	*Dusty environments*	*Yes*	*No*
j.	*Any other hazardous exposures*	*Yes*	*No*

If "yes," describe these incidents of exposures: _____

_____

_____

6. Have you ever had any of the following cardiovascular or heart symptoms?

a.	*Frequent pain or tightness in your chest*	*Yes*	*No*
b.	*Pain or tightness in your chest during physical activity*	*Yes*	*No*
c.	*Pain or tightness in your chest that interferes with your job*	*Yes*	*No*
d.	*In the past two years, have you noticed your heart skipping or missing a beat?*	*Yes*	*No*
e.	*Heartburn or indigestion that is not related to eating*	*Yes*	*No*
f.	*Any other symptoms that you think may be related to heart or circulation problems*	*Yes*	*No*

7. Do you currently take medication for any of the following problems?

a.	*Breathing or lung problems*	*Yes*	*No*
b.	*Heart trouble*	*Yes*	*No*
c.	*Blood pressure*	*Yes*	*No*
d.	*Seizures (fits)*	*Yes*	*No*

8. If you've used a respirator, have you ever had any of the following problems?

(If you've never used a respirator, check the following space and go to question 9.)

a.	*Eye irritation*	*Yes*	*No*
b.	*Skin allergies or rashes*	*Yes*	*No*
c.	*Anxiety*	*Yes*	*No*
d.	*General weakness or fatigue*	*Yes*	*No*
e.	*Any other problem that interferes with your use of a respirator*	*Yes*	*No*

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? *Yes* *No*

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently)? *Yes* *No*

11. Do you currently have any of the following vision problems?

a.	*Wear contact lenses*	*Yes*	*No*
b.	*Wear glasses*		
c.	*Color blind*	*Yes*	*No*
d.	*Any other eye or vision problem*	*Yes*	*No*

12. Have you ever had an injury to your ears, including a broken ear drum? *Yes* *No*

13. Do you currently have any of the following hearing problems?

a.	*Difficulty hearing*	*Yes*	*No*
b.	*Wear a hearing aid*	*Yes*	*No*
c.	*Any other hearing or ear problem*	*Yes*	*No*

14. Have you ever had a back injury? *Yes* *No*

15. Do you currently have any of the following musculoskeletal problems?

a.	*Weakness in any of your arms, hands, legs or feet*	*Yes*	*No*

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (Please circle yes or no.)

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	*Yes*	*No*
2. Have you ever had any of the following conditions?		
a. Seizures (fits)	*Yes*	*No*
b. Diabetes (sugar disease)	*Yes*	*No*
c. Allergic reactions that interfere with your breathing	*Yes*	*No*
d. Claustrophobia (fear of closed-in places)	*Yes*	*No*
e. Trouble smelling odors	*Yes*	*No*
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis	*Yes*	*No*
b. Asthma	*Yes*	*No*
c. Chronic bronchitis	*Yes*	*No*
d. Emphysema	*Yes*	*No*
e. Pneumonia	*Yes*	*No*
f. Tuberculosis	*Yes*	*No*
g. Silicosis	*Yes*	*No*
h. Pneumothorax (collapsed lung)	*Yes*	*No*
i. Lung cancer	*Yes*	*No*
j. Broken ribs	*Yes*	*No*
k. Any chest injuries or surgeries	*Yes*	*No*
l. Any other lung problem that you've been told about	*Yes*	*No*
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	*Yes*	*No*
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	*Yes*	*No*
c. Shortness of breath when walking with other people at an ordinary pace on level ground	*Yes*	*No*
d. Have to stop for breath when walking at your own pace on level ground	*Yes*	*No*
e. Shortness of breath when washing or dressing yourself	*Yes*	*No*
f. Shortness of breath that interferes with your job	*Yes*	*No*
g. Coughing that produces phlegm (thick sputum)	*Yes*	*No*
h. Coughing that wakes you early in the morning	*Yes*	*No*
i. Coughing that occurs mostly when you are lying down	*Yes*	*No*
j. Coughing up blood in the last month	*Yes*	*No*
k. Wheezing	*Yes*	*No*
l. Wheezing that interferes with your job	*Yes*	*No*
m. Chest pain when you breathe deeply	*Yes*	*No*
n. Any other symptoms that you think may be related to lung problems	*Yes*	*No*
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack	*Yes*	*No*
b. Stroke	*Yes*	*No*
c. Angina	*Yes*	*No*
d. Heart failure	*Yes*	*No*
e. Swelling in your legs or feet (not caused by walking)	*Yes*	*No*
f. Heart arrhythmia (irregular heart beat)	*Yes*	*No*
g. High blood pressure	*Yes*	*No*
h. Any other heart problem that you've been told about	*Yes*	*No*

OSHA Respiratory Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1 and to question 9 in Section 2 of Part A do not require a medical examination.

To the employee:

Can you read: Yes No

Your employer must allow you to answer this questionnaire during normal working hours or at a time and place that is convenient for you. To maintain your confidentiality, your employer or supervisor will not look at or review your answers and your employer must tell you how to deliver or send this questionnaire to a health care professional, who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____

2. Your name: _____

3. Your age (to nearest year): _____

4. Sex: Male Female

5. Your height: _____ *feet* _____ *inches*

6. Your weight: _____ *pounds*

7. Your job title: _____

8. A phone number where you can be reached by the health-care professional who reviews this questionnaire (include the area code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire? ___*Yes* ___*No*

11. Check the type of respirator you will use (you can check more than one category):

a. ____ *N, R or P disposable respirator (filter-mask, noncartridge type only)*

b. ____ *Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)*

12. Have you worn a respirator? ___ *Yes* ___*No*

If "yes," what type(s)?: _____

_____